



Cascade ID & Infusion
Specialty Order Form

Patient: _____ DOB: _____ <input type="checkbox"/> M <input type="checkbox"/> F Weight: _____ lbs. Height: _____ ICD-10 Code(s): _____ Diagnosis: _____ Allergies: _____ Primary Care Provider: _____	Ordering Provider: _____ NPI: _____ Practice: _____ Phone: _____ Fax: _____ Contact Name: _____
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REGEN-COV (pre-mixed vials): Casirivimab 600 mg IV & Imdevimab 600 mg IV x 1 dose

PRN-Medication(s):

- Acetaminophen/Tylenol: 650 mg PO
- Diphenhydramine/Benadryl: 25 mg IV
- Ondansetron/Zofran: 4 mg IVP

** We will not be administering the REGEN-COV sub Q this will only be given via IV infusion **

Quick Checklist for REGEN-COV patients.

- I have discussed the EUA requirements and reviewed the fact sheet for the patients, parents or caregiver
- I have informed the patient that they should not receive a COVID vaccine for at least 90 days following the REGEN-COV infusion
- The patient has given verbal consent to receive the REGEN-COV infusion
- Include demographic sheet and if applicable copy of insurance card(s).
- Completed Cascade ID & Infusion Specialty Order Form
- Recent Progress Note
- Positive COVID Laboratory Report

Physician's Signature: _____ **Date:** _____